b. Describe, in writing to the Department, the nature of any emergency necessitating emergency abdominal surgery; and (11-10-81)

c. Under no circumstance can the period between consent and sterilization exceed one hundred eighty (180) days. (11-10-81)

05. Requirements for Sterilization Performed Due to a Court Order. When a sterilization is performed after a court order is issued, the physician performing the sterilization must have been provided with a copy of the court order prior to the performance of the sterilization. In addition he must: (11-10-81)

a. Certify, by signing a properly completed "Consent Form" and submitting the consent form with his claim, that all requirements have been met concerning sterilizations; and (11-10-81)

b. Submit to the Department a copy of the court order together with the "Consent Form" and claim. (11-10-81)

06. Circumstances Under Which Payment Can Be Made for a Hysterectomy. Payment can be made for a hysterectomy only if: (11-10-81)

a. It is medically necessary. A document must be attached to the claim to substantiate this requirement; and (11-10-81)

b. There was more than one (1) purpose in performing the hysterectomy, and the hysterectomy would not have been performed for the sole purpose of rendering an individual permanently incapable of reproducing; and (11-10-81)

c. The patient was advised orally and in writing that sterility would result and that she would no longer be able to bear children; and (11-10-81)

d. The patient signs the "Authorization for Hysterectomy," (HW-0029) or its equivalent, acknowledging receipt of the information. (11-10-81)

091. TARGETED CASE MANAGEMENT FOR PREGNANT PARENTING TEENS AND THEIR INFANTS. The Department will purchase case management (CM) services for qualified pregnant teens only in specific target areas. Services will be provided by qualified providers who have entered into a provider agreement with the Department. The purpose of these services is to assist targeted individuals to gain access to needed medical, social, educational, vocational and other services to promote positive pregnancy outcomes and develop self-sufficiency. (3-2-94)

01. Target Group. Medicaid eligible pregnant teens seventeen (17) years of age or younger at time of conception. Teens who qualify for case management at intake continue to qualify for case management services until the infant is one (1) year of age, so long as the goals of the case management plan have not been met. For purposes of this section, a teen is considered pregnant until 72 hours after delivery. Additionally, any Medicaid eligible teen/infant receiving targeted case management services since October 1, 1993, will be considered part of the target group. (3-2-94)

02. Target Areas. Adams, Washington, Payette, Gem, Canyon and Owyhee counties. (3-2-94)

03. Service Descriptions. Case Management services shall be delivered in accordance with these rules by qualified providers to assist qualified teens/infants in obtaining and coordinating needed health, educational, vocational and social services most appropriate for self-sufficiency. CM services shall consist of the following core functions: (3-2-94)

a. Assessment. A CM provider must assess the patient/recipient's needs through the systematic collection of data to determine current status and needs. Data sources include, but are not limited to, patient/recipient and family interviews, existing available records, and needs tests. The case manager will identify the patient/recipient's current needs, including but not limited to: (3-2-94)

i. Relationship with a primary health care provider; (3-2-94)

ii. Immunization status; (3-2-94)

iii. History of physical exams; (3-2-94)

iv. Family health care utilization practices; (3-2-94)

v. Social and health services currently being used by the family; (3-2-94)

vi. Physical health; (3-2-94)

vii. Mental health; (3-2-94)

viii. Academic functioning; (3-2-94)

ix. Behavior problems; (3-2-94)

x. Social relationships; (3-2-94)

xi. Environmental situations; (3-2-94)

xii. Developmental status; (3-2-94)

xiii. Mobility capabilities; (3-2-94)

xiv. Family functioning; (3-2-94)

xv. Nutritional status and eating disorders; (3-2-94)

xvi. Chemical use/abuse and tobacco use by individual and presence in environment; (3-2-94)

xvii. Future family planning needs; and (3-2-94)

xviii. Other needs as identified by the recipient, and/or family/caretaker. (3-2-94)

b. Development of Plan of Care. Based on the needs assessment, the case manager will develop a plan of care. Planning activities involve making specific decisions regarding the patient/recipient's needs and determining the resources available to meet those needs in a coordinated, integrated fashion. The plan of care will provide for transition to independence, including an expected date and method for achieving such transition. When possible, family members and/or caretakers and appropriate professionals are to be included in the planning process. (3-2-94)

i. Integrated Document. The plan of care is an integrated document which provides the basis for the delivery of services. The plan must be written and identify each problem to be addressed, the expected outcome, the referrals to be made, resources to be used, and identification of responsibilities. (3-2-94)

ii. Review and Update. The case manager and recipient or caretaker will review and update the plan of care as needed, collaborating as necessary with appropriate parties. (3-2-94)

iii. Documentation. The plan of care, and accompanied documents serve as documentation for payment purposes. The patient/recipient's record must include the formal plan of care and updates to the plan, and any narrative documentation reflecting active priorities. It should also include an intake assessment, a copy of a completed intake reporting form, and identification of areas where intervention is needed. (3-2-94)

c. Implementation of Plan of Care. Implementation ensures that the recipient and/or family receives services as indicated in the patient/recipient's plan of care. (3-2-94)

i. Referrals. The case manager will make referrals in a coordinated, planned manner or provide information and assist patient/recipients to self-refer. (3-2-94)

ii. Linking/Coordination of Services. Through negotiation and referrals, the case manager links the recipient to various providers of services/care and coordinates service delivery. Coordination of service delivery includes activities such as assuring that needed services have been delivered, consulting with service providers to ascertain whether they are adequate for the needs of the recipient, and consulting with the client to identify the need for changes in a specific service or the need for additional services. The case manager may refer to his own agency for services but may not restrict the recipient's choice of service providers. It may be necessary to mobilize more than one set of resources to make adequate services available. (3-2-94)

iii. Advocacy. Related advocacy activities are provided to assist the family to achieve the goals of the plan, particularly when resources are inadequate or the service delivery system is nonresponsive. The case manager will negotiate or otherwise assist the recipient/caretaker in accessing appropriate services. Advocacy may include, but is not limited to: (3-2-94)

(a) Intervening with agencies or persons to help individual recipients receive appropriate benefits or services; and (3-2-94)

(b) Assisting the recipient/caretaker to accomplish necessary tasks such as filling out pertinent forms, obtaining necessary documentation or authorization, and finding transportation to services. (3-2-94)

d. Crisis/Urgent Assistance. Crisis/Urgent assistance services are those case management activities that are needed in addition to the assessment, development, and implementation of the plan of care resulting from emergency/urgent situations. These are activities to obtain emergency housing, protection of the patient/recipient, to meet health care needs, or similar activities required by the imminence of the situation. Crisis/Urgent assistance may be provided prior to or after the completion of the plan of care. (3-2-94)

04. CM Provider Qualifications. Case management providers must meet the following criteria: (3-2-94)

a. Operate as an organization with on-site ability to provide a comprehensive service package to pregnant teens that includes JOBS counseling, arrangement for child care services, Child Support Services, WIC, immunizations, sexually transmitted disease service, and family planning; (3-2-94)

b. Have at least four (4) years of experience with, and demonstrated positive outcomes in work with, the targeted group; (3-2-94)

c. Have appropriate liability insurance and be responsible for the withholding and payment of taxes for its employees; and (3-2-94)

d. Be located in the target area. (3-2-94)

05. CM Provider Staff Qualifications. Staff members delivering case management services for the provider organization must meet the following qualifications: (3-2-94)

a. Be a Registered Nurse or a Licensed Social Worker; (3-2-94)

b. Be under the direct supervision of, or a subcontractor of, the provider organization; and (3-2-94)

c. Case manage no more than forty-five (45) individuals at any time. (3-2-94)

06. Recipient's Choice. The qualified patient/recipient will be allowed to choose whether or not she desires to receive CM services. Recipients may also choose the providers of medical and other services under the Medicaid program, subject to restrictions imposed by managed care programs. (3-2-94)

07. Payment for Services. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as CM services, however, the actual provision of the service does not constitute CM. CM does not include the provision of services such as transportation, psychotherapy or counseling, supportive therapy , or training. Medicaid will reimburse only for core services (Subsection 03.) provided to members of the target group by qualified staff. (3-2-94)

a. Payment for CM will not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-2-94)

b. Payment will not be made for CM services provided to individuals who are inpatients in nursing facilities, ICFs/MR, or hospitals. (3-2-94)

c. Medicaid will reimburse for case management services on the same date a recipient is admitted or discharged from a hospital, nursing facility, or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of service delivery. (3-2-94)

d. Reimbursement for the assessment and individual plan of care development shall be paid based on a flat rate established by the Bureau. (3-2-94)

e. Reimbursement for on-going case management services such as review and revision of the plan of care or crisis management shall be made based on an hourly rate for service delivered. The rate will be established by the Bureau. (3-2-94)

f. The Department will not provide Medicaid reimbursement for on-going case management services delivered prior to the completion of the assessments and individual plan of care. (3-2-94)

g. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and individual service plan. (3-2-94)

h. Audit reviews may be conducted by the Department. Review findings may be referred to the Department's Surveillance and Utilization Review Section for appropriate action. (3-2-94)

i. Failure to provide services for which reimbursement has been received or to comply with these rules and regulations will be cause for recoupment of payments for services, sanctions, or both. (3-2-94)

j. The provider will provide the Department with access to all information required to review compliance with these rules.

(3-2-94)

k. The Department will not provide Medicaid reimbursement for case management services provided to a group of recipients. (3-2-94)

08. Record Requirements. The following documentation must be maintained by the provider: (3-2-94)

a. A standard plan of care and progress notes which include the following: (3-2-94)

i. Name, age, race, and ethnicity of recipient; (3-2-94)

ii. Name of the provider agency and the case manager providing the service; (3-2-94)

iii. Date, time, and duration of service; (3-2-94)

iv. Place of service; (3-2-94)

v. Activity record describing the recipient and the service provided; (3-2-94)

vi. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of case management. (3-2-94)

b. Standard forms, including but not limited to: (3-2-94)

i. Intake form; (3-2-94)

ii. Pregnancy outcome forms; (3-2-94)

iii. Tracking forms; and (3-2-94)

iv. Exit forms. The standard forms used by case managers must collect information in the following areas: recipient characteristics; maternity related needs; substance use treatment and education; primary and preventative health services and education; pediatric care; sexual decision-making; nutrition counseling; adoption counseling; child support enforcement services; educational/vocational training needs; economic/housing needs; role/relationship needs; child care needs; transportation; and consumer/homemaking skills. (3-2-94)

092. -- 094. (RESERVED).

095. ABORTION PROCEDURES. (6-1-94)

01. Requirements for Funding Abortions Under Title XIX. The Department will fund abortions under Title XIX only under circumstances where the abortion is necessary to save the life of the woman or in cases of rape or incest as determined by the courts or, where no court determination has been made, if reported to a law enforcement agency. This Subsection is effective retroactively from October 1, 1993. (10-1-93)

02. Requirements for Funding Abortions Solely With State Funds. The Department will fund abortions solely out of state general funds only under circumstances where the abortion is determined to be medically necessary to save the health of the woman. The woman applying for services under this subsection shall apply for and be determined by the Department to be otherwise Medicaid eligible. This Subsection is effective retroactively from February 17, 1994. (2-17-94)

03. Required Documentation For Payment. The following documentation shall be provided: (10-1-93)

a. In the case of rape or incest: (10-1-93)

i. A copy of the court determination of rape or incest must be provided; or (10-1-93)

ii. Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency. (10-1-93)

iii. Where the rape or incest was not reported to a law enforcement agency, two (2) licensed physicians must certify in writing that, in the physicians' professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest to a law enforcement agency. The certification must contain the name and address of the woman; or (10-1-93)

iv. Documentation that the woman was under the age of 18 at the time of sexual intercourse. This Subsection 095.03.a. is effective retroactively from October 1, 1993. (10-1-93)

b. In the case where the abortion is necessary to save the life of the women, two (2) licensed physicians must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman. This Subsection 095.03.b. is effective retroactively from October 1, 1993. (10-1-93)

c. In the case where the abortion is determined to be medically necessary to save the health of the woman, two (2) licensed physicians must certify in writing that the abortion is medically necessary to prevent injury or damage to the health of the woman. The certification must contain the name and address of the woman. This Subsection 095.03.c. is effective retroactively from February 17, 1994. (2-17-94)

096. -- 099. (RESERVED).

099. EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICE COORDINATION. The Department will purchase case management services hereafter referred to as Service Coordination (SC) for Medicaid eligible children age birth to twenty-one (21) years of age who meet medical necessity criteria. (10-1-94)T

01. Medical Necessary Critera. Medical necessity criteria for SC services under EPSDT are as follows: (10-1-94)T

a. Children eligible for SC must meet one of the following diagnostic criteria: (10-1-94)T

i. Children who are diagnosed with a physical or mental condition which has a high probability of resulting in developmental delay or disability, or children with developmental delay or disability. Developmentally delayed children are children with or without established conditions who by assessment measurements have fallen significantly behind developmental norms in one or more of the five functional areas which include cognitive development; physical development including vision and hearing; communication; social/emotional development; and adaptive skills. (10-1-94)T

ii. Children who have or who are at risk of developing special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize disability. Special health care needs may include a wide range of physical, mental, or emotional limitations from birth defects, illnesses, or injuries. See "Children's Special Health Program Diagnostic Eligibility Listing", dated January 1993 or Infant Toddler Program established condition criteria. (10-1-94)T

iii. Children who have, or who are at risk of developing, a severe emotional disturbance. The following criteria are used in assessing children in this group to determine eligibility for case management services:

Disabling condition based upon social functioning criteria; defined condition diagnosable under DSM-III or subsequent revisions or another classification system used by the Department; and expected duration of the condition is at least one year or more than one year. (10-1-94)T

b. Children eligible for SC must have one or more of the following problems associated with their diagnosis: (10-1-94)T

i. The condition requires multiple service providers and treatments. (10-1-94)T

ii. The course of the condition is unpredictable. (10-1-94)T

iii. There is pain, discomfort, or embarrassment to the child from the condition or treatment. (10-1-94)T

iv. The condition may be rare and not well understood by others. (10-1-94)T

v. The condition has resulted in a level of functioning below age norm in one or more life areas, such as school, family,community. (10-1-94)T

vi. There is risk of out-of-home placement or the child is returning from an out-of-home placement as a result of the condition. (10-1-94)T

vii. There is imminent danger to the safety or ability to meet basic needs of the child as a result of the condition. (10-1-94)T

02. Service Descriptions. SC services shall be delivered by eligible providers to assist the Medicaid child and their family to obtain and coordinate needed health, educational, early intervention, advocacy, and social services identified in an authorized SC plan developed by the Department or their contractor. Services must take place in the least restrictive, most appropriate and most cost effective setting. SC services shall consist of the following core functions: (10-1-94)T

a. Coordination/Advocacy, which is the process of facilitating the child's access to the services, evaluations, and resources identified in the service plan. The case manager may advocate on behalf of the child and family for appropriate community resources and coordinate the multiple providers of social and health services defined in the service plan to avoid the duplication of services for the child. (10-1-94)T

b. Monitoring, which is the ongoing process of ensuring that the child's service plan is implemented and assessing the child's progress toward meeting the goals outlined in the service plan and the family's satisfaction with the services. Direct in-person contact with the child and the child's family is essential to the monitoring process. (10-1-94)T

c. Evaluation, which is the process of determining the continued appropriateness of the service plan, the need for a new plan, or whether services should be terminated. Evaluation is accomplished through periodic in-person reassessment of the child, consultation with the child's family, and consultation and updated assessment from other providers. The addition of new services .to the plan or increase in the amount of an approved service on the existing plan must be authorized by the Department prior to implementation. (10-1-94)T

d. Crisis Assistance, which are those SC activities that are needed in emergency situations in addition to those identified on the service plan. These are necessary activities to obtain needed services to ensure the health or safety of the child. Post authorization of emergency services must be obtained within five (5) working days after the provision of the service. To the extent possible the plan should include instructions for families to access emergency services in the event of a crisis. If a need for twenty-four

(24) hour availability of service coordination is identified, then arrangements will be made and included on the plan. (10-1-94)T

e. Encouragement of Independence, which is the demonstration to the child, parents, family, or legal guardian of how to best access service delivery systems. (10-1-94)T

03. SC Provider Agency Qualifications. SC provider agencies must have a valid provider agreement with the Department and meet the following criteria: (10-1-94)T

a. Demonstrated experience and competency in providing all core elements of service coordination services to the target population. (10-1-94)T

b. Level of knowledge sufficient to assure compliance with regulatory requirements. Adherence to provision of provider agreement for EPSDT service coordination. Provider agreement may include, but is not limited to, requirements for training, quality assurance, and personnel qualifications. (10-1-94)T

04. Service Coordination Individual Provider Staff Qualifications. All individual SC providers must be employees of an organized provider agency that has a valid SC provider agreement with the Department. The employing entity will supervise the individual SC providers and assure that the following qualifications are met for each individual SC provider: (10-1-94)T

a. Must be a licensed M.D., D.O.; social worker; R.N.; or have at least a B.A./B.S. in human/health services field; and have at least one (1) year's experience working with children meeting the medical necessity criteria with whom they will be working. (10-1-94)T

b. Individuals without the one (1) year's experience may gain this experience by working for one (1) year under an individual who meets the above criteria. (10-1-94)T

c. Paraprofessionals, under the supervision of a qualified SC, may be used to assist in the implementation of the service plan. Paraprofessionals must meet the following qualifications: be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); be able to read at a level commensurate with the general flow of paperwork and forms; meet the employment standards and required competencies of the provider agency; and meet the training requirements according to the agency provider agreement. (10-1-94)T

d. Pass a criminal history background check. (10-1-94)T

e. The caseload of service coordinators will be limited so as to assure the quality of services provided. At no time will the total caseload of a service coordinator be so large as to violate the purpose of the program or adversely affect the health and welfare of any children served by the service coordinator. (10-1-94)T

05. Recipient's Choice. The eligible child's family, custodian, or legal guardian will be allowed to choose whether or not they desire to receive SC services. All eligible children and their families who choose to receive SC services will have free choice of qualified SC providers as well as the qualified providers of medical and other services under the Medicaid program. (10-1-94)T

06. Payment for Services. When a recipient is enrolled in managed care/Healthy Connections, the referral for assessment and services must be authorized by primary care providers. When an assessment indicates the need for medical, advocacy, psychiatric, social, educational, early intervention or other services, referral or arrangement for such services may be included as SC services; however, the actual provision of the service does not constitute

SC. Medicaid will reimburse for SC services only when ordered by a physician and provided by qualified staff of an approved provider agency or their contractor to eligible children who meet the medical necessity criteria. (10-1-94)T

a. Payment for SC will not duplicate payment made to public or private entities under other program authorities for the same purpose. (10-1-94)T

b. Payment will not be made for SC services provided to children who are inpatients in nursing facilities or hospitals, other than activities performed within the last thirty (30) days of residence which are directed toward discharge and do not duplicate services included in the facility's content of care. (10-1-94)T

c. Reimbursement for ongoing SC services shall be paid on a fee for service basis for service delivered. The rate shall be established by the Bureau of Medicaid Policy and Reimbursement. (10-1-94)T

d. Medicaid reimbursement shall be provided only for the following SC services: (10-1-94)T

i. Face to face contact between the service coordinator and the eligible child, the child's family members, custodian, legal representative, primary care givers, service providers, or other interested groups or persons; (10-1-94)T

ii. Telephone contact between the service coordinator and the child, the child's service providers, the child's family members, custodian or legal guardian, primary caregivers, legal representative, or other interested persons. (10-1-94)T

e. Except for crisis assistance the Department will not provide Medicaid reimbursement for ongoing SC services delivered prior to development of the plan by the Department. (10-1-94)T

f. Audit reviews will be completed by the Department. (10-1-94)T

g. Plans must be reviewed and re-authorized by the Department/Contractor at least annually. Documentation of provision of services will be reviewed and progress toward expected outcomes will be evaluated. Satisfaction of consumers will be determined according to provisions included in the provider agreement. (10-1-94)T

h. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (10-1-94)T

i. The Department will not provide Medicaid reimbursement for SC services provided to a group of children at the same time. (10-1-94)T

j. Medicaid will reimburse for SC services on the same date a child is admitted to a hospital, nursing facility, or other institutional setting, so long as the child is not yet admitted at the time of the service delivery. (10-1-94)T

07. Record Requirements. The following documentation must be maintained by the provider: (10-1-94)T

a. Name of eligible child; and (10-1-94)T

b. Name of provider agency and person providing the service; and (10-1-94)T

c. A copy of the current approved SC plan which includes the expected outcomes and objectives and is signed by the child's parents, custo-

dian or legal guardian, and the authorizing representative of the Department; and (10-1-94)T

d. Date, time, and duration of service; and (10-1-94)T

e. Place of service; and (10-1-94)T

f. Activity record describing the child and the service provided; and (10-1-94)T

g. Documented review of progress toward each SC service plan goal; and (10-1-94)T

h. Documentation justifying the provision of crisis assistance to the child. (10-1-94)T

100. HEALTH CHECK -- EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT). Services under Health Check are available to all MA recipients up to and including the month of their twenty-first (21st) birthday. (12-31-91)

01. EPSDT Services. EPSDT services include diagnosis and treatment involving medical care within the scope of MA, as well as dental services, eyeglasses, and hearing aids, and such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in the Idaho Title XIX State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. (1-27-91)

a. The Department will set amount, duration and scope for services provided under EPSDT. (1-27-91)

b. Needs for services discovered during an EPSDT screening which are outside the coverage provided by the rules governing Medical Assistance must be shown to be medically necessary and the least costly means of meeting the recipient's medicaid needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physicians's assistant. (3-22-93)

c. The Department will not cover services for cosmetic, convenience or comfort reasons. (1-27-91)

d. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in these rules specifically as a Medicaid covered service will require preauthorization for medical necessity prior to payment for that service. (8-1-92)

e. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Idaho Medicaid program will not be subject to the existing amount, scope, and duration, but will be subject to the authorization requirements of those rules. The additional service must be documented by the attending physician as to why it is medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Bureau of Medicaid Policy and Reimbursement will be required prior to payment. (3-22-93)

f. Those services that have not been shown or documented by the attending physician to be the least costly means of meeting the recipient's medical needs are the responsibility of the recipient. (8-1-92)

02. Well Child Screens. (8-1-92)

a. Periodic medical screens should be completed at the following intervals as recommended by the AAP, Committee in Practice and Ambulatory Medicine, September 1987. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services." EPSDT RN screeners will